CAPITAL INTERNAL MEDICINE ASSOCIATES, P.C.

3955 Patient Care Drive, Suite A, Lansing Michigan 48911
Phone: (517)374-7600 Fax: (855)495-5457

REFERRAL FORM

When referring, you **must include: Patient demographics, clear copy of insurance cards, and recent office notes or testing pertaining to referring diagnoses. If not completed in its entirety form may be returned to be completed.**

Please specify the appointment request: **Diagnosis:**

	CARDIOLOGY TESTING		ULTRASOUND		OTHER TESTING/SPECIALITIES
	Consult with Dr. Sherrie Brooks		Liver		PFT – Pre & Post
	Nuclear Stress Test (Lexi Scan)		Kidney/Bladder		PFT - Complete
	Stress Test w/Cardiologist		Prostate - BX		Bone Density
	Echocardiogram or Stress Echo		Breast		Podiatry with Dr. Ingrid Stines
	Holter Monitors (24hr/48hr/21 day)		Thyroid		Infectious Disease with Dr. Chris Farnum
	EKG		Gall Bladder		Aesthetics with Abby Richmond
	TEE		Aorta		Stress Test with Tech & Internist
	Diagnostic Heart Catheterization		Spleen		**A NEW BEGINNING OBGYN**
	Renal Doppler		Pancreas		Consult with: Dr. R. Seiler, Dr. J. Witters
	Carotid Doppler		Pelvic		Dr. M. Maser or Dr. J. Mirate
	Arterial Doppler		Abdomen – Complete		Dr. J. Weiss with **CIMA Breast Center**
			Breast Ultrasound		Mammogram

Patient Last Name:_____First_____MI_____

Gender: M / F DOB: ___/___/___ Marital Status: S M D Separated SSN:_____-_____-_____

Home address: _____Apt # _____

City:_____ State:_MI__ Zip:_____ Phone:_____Alt Phone:_____

Spouse Full Name:_____DOB:_____

Referring Physician:_____Private Phone #_____Fax_____

Primary Care Physician:_____Private Phone #_____Fax_____

Type of Insurance (Primary)_____Contract #_____

Subscriber_____Relationship_____DOB_____

Type of Insurance (Secondary)_____Contract #_____

Subscriber_____Relationship_____DOB_____

Has this testing been performed before? _____ Date: _____ Location: _____

Please fax completed form to 855-495-5457 and we will contact the patient directly to schedule.

APPOINTMENT SCHEDULING CONFIRMATION		
Appt Date:	Time:	With Dr.

THANK YOU FOR YOUR REFERRAL

OFFICE USE ONLY

Patient Notified: Yes_____No_____ Packet Mailed: ____/____/_____ Scheduled By:_____